

MODELS OF TREATMENT FOR OFFENDERS WHO ABUSE CHILDREN

OVERVIEW OF SEX OFFENDER TREATMENT PROGRAMS

ABEL, G.G., OSBORN, C., ANTHONY, D., & GARDOS, P. (1992). CURRENT TREATMENTS OF PARAPHILIACS. *ANNUAL REVIEW OF SEX RESEARCH*, 225-290.

The authors provided an update of treatment components over the past 10 years (circa 1992). The advances made in behavior therapy include covert sensitization, olfactory aversion, combined covert sensitization and olfactory aversion, imagined desensitization therapy, modified aversive behavioral rehearsal, masturbatory reconditioning, thematic shift, fantasy alternation, directed masturbation, satiation, and electrical aversion. The developments made in pro-social behavior development include social skills training, assertiveness training, and sex education. Advances made in cognitive interventions have consisted of cognitive restructuring and victim awareness. The authors provided a detailed description of the relapse prevention model, in conjunction with an overview concerning the outcome data of cognitive behavioral and relapse prevention treatment programs. A discussion is included concerning the various pharmacological treatment interventions, hormonal agents (CPA and MPA), as well as the legal and ethical issues associated with their use. The authors concluded that treatment with cognitive behavioral and pharmacological intervention is effective and incarceration without treatment appears destined to produce relapse.

BARBAREE, H.E., & MARSHALL, W.L. (1991). TREATMENT OF THE ADULT MALE CHILD MOLESTER. IN C.R. BAGLEY & R.J. THOMLISON (EDS.). *CHILD SEXUAL ABUSE: CRITICAL PERSPECTIVES ON PREVENTION, INTERVENTION, AND TREATMENT* (PP. 217-256). TORONTO, ONT.: WALL & EMERSON.

This article is a critical review of a wide range of approaches to the treatment of sex offenders. It provided a brief outline on the characteristics of

child molesters and discusses the methodological issues associated with evaluating treatment outcome. In addition, it discussed various treatment approaches, including organic treatment, non-behavioral psychotherapy, comprehensive cognitive-behavioral therapy, and the treatment of the sex offender in the context of the mental health and correctional systems. The discussion pointed to the difficulties in conducting treatment outcome research in this area and offers suggestions as to what might be considered the minimum requirements of a treatment outcome study. The authors reported that applying these criteria to the extant reports of treatment for the sex offender leads to the conclusion that the reports to date are not sufficient to evaluate most treatment programs; however, they outlined a number of guidelines for treatment.

BARBAREE, H.E., PEACOCK, E.J., CORTONI, F., MARSHALL, W.L., & SETO, M. (1998). ONTARIO PENITENTIARIES' PROGRAM. IN W.L. MARSHALL (ED.). *SOURCEBOOK OF TREATMENT PROGRAMS FOR SEXUAL OFFENDERS* (PP. 59-77). NEW YORK: PLENUM PRESS.

The authors described the treatment programs for incarcerated sex offenders sponsored by the Correctional Services of Canada with emphasis on the Warkworth Sexual Behavioral Clinic and the Bath Institution Sex Offenders' Program. The programs utilized a cognitive behavioral approach and group therapy. The Warkworth program was established in 1989 in a medium security federal penitentiary located in Toronto and houses 650 inmates serving sentences of two or more years. Approximately half of these offenders were convicted of a sexual offense or a violent offense in which sexual motivation or behavior was considered to be important. In a follow-up group of 202 offenders, 13 individuals committed a new sexual offense and an additional four individuals committed a new violent offense but not a sexual offense. A total of 36 individuals committed a new offense of any kind. After an average follow-up period of 2.5 years there was a sexual offense recidivism rate

of 6.4%. These rates compare favorably with the re-offense rates reported by other larger treatment programs. However, they are too low to conduct discriminate function or logistic regression analysis. The Bath program, which operates within a federal penitentiary, was established in 1991 and is directed by William Marshall. The penitentiary is a "step down" from medium security but offers more constraints than a minimum security facility and houses 300 inmates, 50% of which are sex offenders. The program offers two levels of treatment – offenders who are deemed to be low/low-moderate risk (open groups) and moderate or above (closed groups). Tentative outcome evaluations of the first 107 men treated and released revealed a 2.7% recidivism rate, but so far it has been impossible to estimate the untreated base rate.

BECKETT, R. (1998). COMMUNITY TREATMENT IN THE UNITED KINGDOM. IN W.L. MARSHALL (ED.). *SOURCEBOOK OF TREATMENT PROGRAMS FOR SEXUAL OFFENDERS* (PP. 133-152). NEW YORK: PLENUM PRESS.

Beckett discussed the STEP study (Beckett et al., 1994) that evaluated six representative community-based treatment programs for sex offenders, in conjunction with the Gracewell Clinic, a specialist residential treatment program for child abusers. Beckett examined the impact treatment had on the clients in order to identify which elements of the treatment programs were the most effective and to formulate recommendations on how programs might improve their effectiveness as well as to collect data for a long-term reconviction study. Of the programs selected, two were rolling long-term, open-ended programs and three were short-term, intensive programs offering on average 54 hours of treatment over two weeks. The other was a short-term intensive week program followed by the client seeing his own probation officer and one of the group leaders as a team. In total, 52 child abusers were systematically assessed before and after 54 hours of community-based treatment and these were compared with clients treated by the residential program who had on average received 462 hours of therapy. Cognitive behavioral methods were utilized in all of the programs. Clients were tested pre and post participation in treatment on personality and offense-specific measures. At the

end of treatment, 54% of child abusers displayed profiles that fell largely within the non-offending range. The results also illustrated the relationship between treatment change and length of time in therapy. Highly deviant child abusers needed a considerably longer amount of time in treatment before they reached a non-deviant "successfully treated" profile. Overall, 65% of the men who began treatment with a low deviancy profile were successfully treated, compared to only 42% of men who started treatment with a highly deviant profile. Short-term group work successfully treated 65% of offenders entering treatment with low deviancy profiles. With highly deviant men, however, short-term programs were largely unsuccessful. Less than 20% of these offenders had treated profiles by the end of treatment. Long-term therapy, averaging 462 hours of treatment, was more successful than short-term therapy in treating low deviancy men (80% compared with 62%), and considerably more successful in treating highly deviant men (60%). In addition to reducing denial, justifications, and cognitive distortions, long-term treatment was particularly successful in improving the self-esteem, assertiveness, and intimacy skills of these highly deviant child molesters. Currently treatment programs still vary considerably in the number of treatment hours they offer. The amount of time spent in treatment, per offender, can range from 8 to 225 hours per year, with an average of 81 hours. Seventy-percent of the programs offer weekly treatment sessions, with 31% offering intensive treatment on a daily basis. Group work remains the most common form of treatment intervention (97%), though in the majority of programs, co-working, ongoing supervision by individual probation officers, and involvement with mental health professionals are also cited as parallel treatment interventions. With regard to treatment intervention, the most commonly cited goals are increasing victim empathy, controlling sexual arousal, reducing denial, and improving family relationships. Interestingly, less than half of the programs surveyed still cite relapse prevention as an explicit goal.

ECCLES, A., & WALKER, W. (1998). COMMUNITY-BASED TREATMENT WITH SEX OFFENDERS. IN W.L. MARSHALL (ED.). *SOURCEBOOK OF TREATMENT PROGRAMS FOR SEXUAL OFFENDERS*. (PP. 93-103). NEW YORK: PLENUM PRESS.

Eccles & Walker focused on Forensic Behavior Services, which utilizes a cognitive behavioral perspective in conjunction with a relapse prevention approach. The authors stated that in general, there is sufficient evidence to provide optimism that child abusers can receive treatment that lowers their risk to re-offend. With regard to treatment efficacy, the article refers to Marshall & Barbaree (1988), who followed child sexual offenders treated at the Kingston Sexual Behavior Clinic for an average of approximately four years. They found that recidivism rates were markedly lower for treated than for untreated groups. Specifically, the comparisons of recidivism rates for treated versus untreated groups were 18% for molesters of non-familial male children, and 8% versus 22% for incest offenders.

FISHER, D., & BEECH, A.R. (1999). CURRENT PRACTICE IN BRITAIN WITH SEXUAL OFFENDERS. *JOURNAL OF INTERPERSONAL VIOLENCE*, 14 (3), 240-256.

Discussed the management and treatment of sex offenders in Britain and provides a brief overview of the first in a series of treatment evaluation studies commissioned by the British government. According to a 1993 survey of the provision of community-based treatment programs for sex offenders, only three of the 63 treatment programs were in existence for more than five years. The increase in treatment programs has been attributed to an increased awareness by the public owing to media attention given to the recidivism of sexual offenders and the realization that these offenders rarely receive any treatment. The authors analyzed sex offender treatment in the community, hospitals, and prisons. An overview of the Sexual Offender Treatment Evaluation Project is also discussed. Cognitive behavioral therapy with reliance on Finkelhor's four preconditions model and the offense cycle was found to be widely used by probation services. Even though the programs were generally successful in covering the specific cognitive areas of therapy, they had little or no behavioral component. Little evidence was found in any of the programs of offenders having been given any formal training in relapse prevention skills. Prior to treatment, the child abusers in the sample were found to be significantly different from the comparison group of non-offenders. Typically, they were emotionally isolated individuals, lacking self-confidence. There were under-assertive, poor at appreciating the

perspective of others, and ill-equipped to deal with emotional distress. They characteristically denied or minimized the extent of their sexual offending and problems. A significant portion were found to have little empathy for their victims, strong emotional attachments to children, and a range of distorted attitudes and beliefs in which they portrayed children as able to consent to-and not be harmed by sexual contact with adults. Treatment effectiveness was measured using a battery of psychological tests that measured the areas covered in the treatment program. Individuals were regarded as having shown a treatment effect when their post-treatment test profiles were within a normal range of responding on the measures used. The results revealed that more than half of the total sample showed a treatment effect. All of the programs were found to have a significant effect on offenders' willingness to admit to their offenses and sexual problems. The programs appeared to have significantly reduced the extent to which offenders justified their offending as well as the offenders' distorted thinking about children and sexuality.

GORDON, A., & HOVER, G. (1998). THE TWIN RIVERS SEX OFFENDER TREATMENT PROGRAM. IN W.L. MARSHALL (ED.). *SOURCEBOOK OF TREATMENT PROGRAMS FOR SEXUAL OFFENDERS*. (PP. 3-15). NEW YORK: PLENUM PRESS.

The Twin Rivers Sex Offender Treatment Program was established in 1988 and operates within an 816-bed medium security prison. Of those 816-beds, 200 are dedicated to the sex offender treatment program that consists of a staff of 27 individuals. The therapy utilized by the program consists of cognitive behavioral treatment techniques placed within a relapse prevention framework. Most treatment occurs in both group and individual formats. As of July 1996, 11.4% of the 132 released offenders who completed treatment between 1988 and 1992 had returned to prison for a new sexual offense; of the 235 released offenders who completed treatment between 1993 and 1995, only 4.3% had returned to prison for a new sexual offense.

HORTON, T. (2002). *DUCKING FROM ANGELS - FALLING FROM GRACE: A TREATMENT SUPPLEMENT FOR CLERGY WHO SEXUALLY OFFEND*. BLOOMINGTON, IL: ACME HALO PUBLISHING.

Ducking from Angels is a treatment supplement for sex offender treatment providers to utilize when treating sexually offending clergy of all faiths. It focuses on the authority and trust that was broken by clergy offenders and the unique trauma that the victims of clergy offenders have endured. It is not a treatment program, but as the title implies it is a treatment supplement meant to augment existing sex offender treatment curriculums. The main premise of the supplement is to counteract the cognitive distortions that religious sex offenders hold in order to carry on their misdeeds. It is argued that many of these offenders use Biblical verses as an excuse to commit sexual acts on children. To that end, this guide enables clinicians to use other quotes from the Bible to help encourage change, closure, and empathy in these offenders. In a respectful but powerful way, *Ducking from Angels* becomes a mirror for the offender, encouraging him to honestly look at himself and the damage he has done beyond any potential facades that religious titles or clergy collars can provide.

HUDSON, S.M., WALES, D.S., & WARD, T. (1998). KIA MARAMA: A TREATMENT PROGRAM FOR CHILD MOLESTERS IN NEW ZEALAND. IN W.L. MARSHALL (ED.), *SOURCEBOOK OF TREATMENT PROGRAMS FOR SEXUAL OFFENDERS*. (PP. 17-28). NEW YORK: PLENUM PRESS.

This program in New Zealand was established in 1989 and is housed in a sex offender specific unit with 60 self-contained rooms. The structure of the program is entirely group based and utilizes behavioral treatment within a relapse prevention framework, where individual therapy is kept to a minimum. As of November 1996, 335 men successfully completed the program and have been released. The mean period individuals are considered to be "at risk" is three years and two months (range, 0-5 years 9 months). Twelve of these men have been reconvicted of a sexual crime yielding a reconviction rate of 3.6%.

KEAR-COLWELL, J., & BOER, D.P. (2000). THE TREATMENT OF PEDOPHILES: CLINICAL EXPERIENCE AND THE IMPLICATIONS OF RECENT RESEARCH. *INTERNATIONAL JOURNAL OF OFFENDER THERAPY AND COMPARATIVE CRIMINOLOGY*, 44 (5), 593-605.

The authors contend that the present approaches utilized to treat the pedophile are not as effective as they should be. The recent developments in the application of attachment theory and the treatment of the "difficult client" may lead to improvements in the treatment of such individuals. Attention is drawn to some of the characteristics that pedophiles have in common with personality disordered individuals and with the difficult client. One conclusion is that confrontation during treatment could be counter therapeutic, if not anti-therapeutic, when used in treating the pedophile. It is postulated that other more empathic and supportive approaches are needed, at least at the beginning of the treatment process. The authors discussed the incorporation of the tenets of attachment theory at the initial stages of treatment in order to develop a therapeutic alliance as opposed to a confrontational approach.

LAWS, D.R., MARSHALL, W.L. (2003). A BRIEF HISTORY OF BEHAVIORAL AND COGNITIVE BEHAVIORAL APPROACHES TO SEX OFFENDERS: PART 1. EARLY DEVELOPMENTS. *SEXUAL ABUSE: A JOURNAL OF RESEARCH AND TREATMENT*, 15 (2), 75-92.

This article outlined the development of behavioral and cognitive behavioral treatment of sex offenders from the mid-1800s to 1969. It explored the role of Sigmund Freud and noted that a broad scientific interest in deviant sexual behavior was well established by 1900. John B. Watson and Alfred Kinsey were prominent in the development of behavioral approaches in the early to mid-20th century. A combination of behavioral and cognitive behavioral treatments began to emerge in the late 1960s. Penile Plethysmography (PPG) was developed in 1957, by Kurt Freund, in response to the sexual preference hypothesis. Despite many criticisms of the PPG, it remains a popular assessment tool and continues to be widely used. Earlier non-behavioral treatment approaches were important in establishing that sexual offenders could be engaged in treatment. It is now evident that the sexual preference hypothesis, underpinning behavioral approaches to deviant sexuality, failed to account for the complexity of such behaviors. Gebhard et al. (1965) provided extensive details of the features of sexual offenders, many of which distinguished them from nonsexual offenders and from non-offenders. On these bases, Gebhard et al. were able to classify sexual offenders into sub-

types that differed on specific features. This empirically derived classification began a process that recently resulted in the sophisticated systems of Knight and Prentky (1990, 1993). Gebhard et al (1965) were also among the first researchers to demonstrate that some child molesters were violent toward their victims, an observation subsequently confirmed by Marshall and Christie (1981). The earliest behavioral approaches reflected the view that deviant sexual behavior was a distorted manifestation for pedophilia and other paraphilias. Exhibitionists and child molesters were treated with electrical aversion therapy; the modification of sexual fantasies was the target of efforts applied to sadists and voyeurs. However, there was limited evidence on the long-term effects on overt behavior using these techniques.

LAW, D.R., MARSHALL, W.L. (2003). A BRIEF HISTORY OF BEHAVIORAL AND COGNITIVE BEHAVIORAL APPROACHES TO SEX OFFENDERS: PART 2. THE MODERN ERA. *SEXUAL ABUSE: A JOURNAL OF RESEARCH AND TREATMENT*, 15 (2), 93-120.

The authors continued their review of the treatment literature by providing an overview of the advances in treatment during the 1970s. The most important developments in the 1970s include: further development of phallometric evaluations in assessment and the associated focus on modifying sexual preferences; introduction of cognitive processes; and the first description of more comprehensive treatment programs. In the early 1970s cognitive psychology began to penetrate the field with particular emphasis upon social skills training, assertiveness, sexual dysfunctions, and gender role behavior. The first conference, at which sexual offender issues were discussed from a behavioral or cognitive behavioral perspective was in 1975 and later became known as the Association for the Treatment of Sexual Abusers (ATSA). The most significant innovation of the 1980s was the adaptation from the addictions field of the relapse prevention model, as well as the formulation of social learning theories of sexual offending. Further, a wide variety of programs described targets such as sexual preferences, sex education, empathy, social skills, self-esteem, substance abuse, anger management, and relapse prevention. The final important development of the

1980s was the beginnings of the work on classificatory (or taxonomic) systems applied to sexual offending. Unlike prior attempts at classification, these models were empirically driven and refined by repeated research. The 1990s were characterized by an explosion of treatment programs and a remarkable increase in the publication of research articles; the emergence of strictly actuarial approaches to risk assessment; the construction of theories describing the cognitions, emotions, and intimacy in sexual offenders; and the introduction of the "self-regulation" model as a revision of the relapse prevention model.

MANN, R.E., & THORNTON, D. (1998). THE EVOLUTION OF A MULTISITE SEXUAL OFFENDER TREATMENT PROGRAM. IN W.L. MARSHALL (ED.). *SOURCEBOOK OF TREATMENT PROGRAMS FOR SEXUAL OFFENDERS* (PP. 47-57). NEW YORK: PLENUM PRESS.

The authors discussed a national strategy for the treatment of sex offenders in England. Since then, the Sex Offender Treatment Program (SOTP) has been established in 25 correctional facilities. The program utilizes a cognitive behavioral approach and group therapy. No outcome results are present at this time.

MARSHALL, W.L. (1999). CURRENT STATUS OF NORTH AMERICAN ASSESSMENT AND TREATMENT PROGRAMS FOR SEXUAL OFFENDERS. *JOURNAL OF INTERPERSONAL VIOLENCE*, 14 (3), 221-239.

The author discussed how treatment programs have become more empirically based since the advent of cognitive behavioral therapy in the early 1970s. Marshall described a hypothetical program that includes the assessment of offenders in eight areas – sexual behavior, social functioning, life history, cognitive processes, personality, substance use, physical problems, and relapse-related issues. Further, he went on to describe the structure, process, and content of treatment.

MARSHALL, W.L. (1996). ASSESSMENT, TREATMENT, AND THEORIZING ABOUT SEX OFFENDERS: DEVELOPMENTS DURING THE PAST TWENTY YEARS AND FUTURE DIRECTIONS. *CRIMINAL JUSTICE AND BEHAVIOR*, 23 (1), 162-199.

This article considered developments during the past 20 years in the assessment and treatment of sex offenders and in theoretical interpretations of their behavior. Marshall reviewed research indicating that in the field of assessments there is a move toward including more cognitive features. One interpretation of the evidence to date suggests that phallometry has been overvalued and that considerable work remains to be done on the psychometric aspects of erectile measurement. Treatment also has moved in a more cognitive direction, but the addition of a relapse prevention approach has been the most significant innovation. Theory development is accelerating, but there needs to be more emphasis on developing and refining our specific constructs rather than elaborating broad explanatory theories.

MATSON, S. (2002). SEX OFFENDER TREATMENT: A CRITICAL MANAGEMENT TOOL. *CORRECTIONS TODAY*, 64 (6), 114-118.

The author described the uses of cognitive behavioral and psychotropic interventions (SSRIs) to treat sex offenders. Matson concluded that effective treatment interventions incorporate a variety of approaches, including cognitive behavioral techniques, relapse prevention strategies, psychopharmacology, group therapy, and treatment planning that addresses both the risks and needs of individual offenders. He suggested that the most comprehensive approach to managing sex offenders involves strategies that emphasize collaboration and information-sharing while employing individualized supervision plans and the use of sex offender specific treatment.

POLIZZI, D.M., MACKENZIE, D.L., & HICKMAN, L.J. (1999). WHAT WORKS IN ADULT SEX OFFENDER TREATMENT? A REVIEW OF PRISON-AND NON PRISON-BASED TREATMENT PROGRAMS. *INTERNATIONAL JOURNAL OF OFFENDER THERAPY AND COMPARATIVE CRIMINOLOGY*, 43 (3), 357-374.

An evaluation of 21 sex offender prison and non-prison-based treatment programs was undertaken using the format of the University of Maryland's 1997 report to the U.S. Congress. Eight of the studies were deemed as being too low in scientific merit to include in assessing the effectiveness of the treatment. Of the remaining studies, approximately

50% showed statistically significant findings in favor of sex offender treatment programs. Of six studies that showed a positive treatment effect, four incorporated a cognitive-behavioral approach. Non prison-based sex offender treatment programs were deemed as being effective in curtailing future criminal activity. Prison-based treatment programs displayed promise, but the evidence is not strong enough to support a conclusion that such programs are effective. Few of the studies focused on particular types of sex offenders. Thus, the researchers were unable to formulate any type of conclusion concerning the effectiveness of programs for different sex offender typologies.

SPENCER, A. (1998). PETERHEAD PRISON PROGRAM. IN W.L. MARSHALL (ED.). *SOURCEBOOK OF TREATMENT PROGRAMS FOR SEXUAL OFFENDERS* (PP. 29-46). NEW YORK: PLENUM PRESS.

The Peterhead Prison Program operates out of a maximum security penitentiary and is owned and operated by basic prison (correctional) staff. Sex offenders comprise at least 85% of the prison population. The program is group based and employs cognitive behavioral techniques. There are no outcome results for this program available at this time.

COGNITIVE BEHAVIORAL TREATMENT AND RELAPSE PREVENTION

AYTES, K.E., OLSEN, S.S., ZAKRAJSEK, T., MURRAY, P., & IRESON, R. (2001). COGNITIVE/ BEHAVIORAL TREATMENT FOR SEXUAL OFFENDERS: AN EXAMINATION OF RECIDIVISM. *SEXUAL ABUSE: A JOURNAL OF RESEARCH AND TREATMENT*, 13 (4), 223-231.

The authors reviewed a cognitive behavioral treatment program in Jackson County, Oregon, that was established in 1982. Offenders were mandated to participate in this community-based program upon conviction of a felony or misdemeanor sexual offense. These offenders averaged between two and three years of participation. A group of offenders who participated in the Jackson County program between 1985 and 1995 was identified through archival data from the Oregon Department of Corrections. The data revealed success or non success in treatment, as well as any new convictions for

sexual or nonsexual offenses. A control group of nonsexual offenders in Jackson County, and a group of sexual offenders in Linn County who were not in a treatment program were also studied. As hypothesized, those Jackson County offenders who successfully completed treatment had lower recidivism rates than those who were unsuccessful in the program. The observed effect of the program was particularly strong for offenders who remained in treatment for one year or more. When review was restricted solely to those participants, the re-offense rate for Jackson County offenders was reduced by over 40% when compared with Linn County offenders. These optimistic findings support the need for comprehensive treatment programs with a cognitive behavioral emphasis.

BEECH, A., & FISHER, D. (2000). MAINTAINING RELAPSE PREVENTION SKILL AND STRATEGIES IN TREATED CHILD ABUSERS. IN D.R. LAWS (ED.). *REMAKING RELAPSE PREVENTION WITH SEX OFFENDERS* (PP. 455-465). CALIFORNIA: SAGE PUBLICATIONS.

This chapter described a relatively quick and easy way of evaluating the extent to which offenders have successfully engaged in the relapse prevention (RP) part of treatment. A newly developed questionnaire was utilized in order to measure change in behavior as a function of treatment. This measurement assesses an offenders' awareness of their own risk situations and use of appropriate coping strategies to deal with such risky situations. An evaluation of a treatment program for imprisoned sex offenders in the United Kingdom found that this instrument was effective in measuring changes in RP skills from the beginning to the end of treatment. More interestingly, when completed again some months after the end of treatment, results from the measure indicated that only men who had also shown significant changes in areas typically targeted in cognitive-behavioral therapy maintained their RP skills. This was not noticeable among men who were no longer in prison and who had gone through a fairly regular treatment regime. Results support the need for both maintenance programs to prevent deterioration in the community and follow-up testing to assess current level of relapse prevention skills.

ECCLES, A., & MARSHALL, W.L. (1999). RELAPSE PREVENTION. IN W.L. MARSHALL (ED.). *THE DEVELOPMENT OF COGNITIVE BEHAVIORAL TREATMENT OF SEX OFFENDERS* (PP. 127-146). ENGLAND: JOHN WILEY & SONS, LTD.

This chapter discussed the development of the relapse prevention model by Marlatt in response to the clinical difficulties associated with the treatment of substance abusers. The authors reviewed and critiqued the Marke-Pithers Model as well as Ward's Model of the offense chain. They noted two potential problems with relapse prevention: (1) clients would be overwhelmed by having to learn the complex language of Relapse Prevention, by having to detail each feature of their offense chain, and by having to provide a lengthy series of plans to prevent a relapse; (2) making treatment (i.e., the aspect of the Relapse model that Pithers, 1990, refers to as the "internal self-management dimension") overly elaborate, and coupling that with extensive post-release supervision, send a message to the client that we believe they can manage their lives on their own. The authors outlined their attempt to apply a modified Relapse Prevention approach (which includes some cognitive approaches) with three main features: (1) the development of the offense chain; (2) the generation of plans to deal with potential future problems; and (3) the delineation of warning signs that serve to indicate to the offender and his supervisor that he is slipping back into problematic behavior. However, the authors noted that even though they have not yet evaluated the Relapse Prevention component, other researchers have and found support for the value of the Relapse component in achieving its goals. Despite this evidence these studies are limited due to methodological problems.

FERNANDEZ, Y.M., & MARSHALL, W.L. (2000). CONTEXTUAL ISSUES IN RELAPSE PREVENTION TREATMENT. IN D.R. LAWS (ED.). *REMAKING RELAPSE PREVENTION WITH SEX OFFENDERS* (PP. 225-235). CALIFORNIA: SAGE PUBLICATIONS.

This chapter suggested that the context within which treatment is provided can have a significant influence on the degree to which the clients change. The article attempted to answer the following questions: Is it best to adopt an individual one-on-one

approach or does all or most of treatment occur in groups; Should we employ open or closed-group formats; Or should treatment be seen as a set of psycho-educational components or as a therapeutic process having a guide set of treatment targets? The authors discussed their sex offender program at the Bath Institution, which includes a Relapse model with open group formats. The focus of this program is placed on approach goals rather than avoidance goals.

HANSON, K. (2000). WHAT IS SO SPECIAL ABOUT RELAPSE PREVENTION? IN D.R. LAWS (ED.), *REMAKING RELAPSE PREVENTION WITH SEX OFFENDERS* (PP. 27-38). CALIFORNIA: SAGE PUBLICATIONS.

This chapter discussed the basic principles of Relapse Prevention (RP) and outlined some of the positive and negative aspects of this treatment approach. Hanson promoted the Relapse model as a means of identifying and avoiding high-risk situations and providing a medium through which therapists and offenders can discuss offense behavior. However, he argued that some implications of Relapse Prevention have generated pointless distractions for both therapists and offenders. The chapter also questioned how the more innovative concepts of Relapse Prevention, such as the abstinence violation effect or the lapse/relapse distinction, accurately describe the problem faced by sex offenders. The author offered evidence that sex offenders often lack the motivation that is the prerequisite of Relapse Prevention's interventions and that offenders whose crime patterns do not match the assumption of the model's approach (i.e., negative affect, covert planning, etc.) are unlikely to derive benefit from attempts to force their accounts into a standard Relapse Prevention mold. The model's inability to conceive of untreated, low-risk offenders has diverted attention away from the majority of offenders who naturally desist and has contributed to some sex offenders receiving interventions poorly suited to their needs.

HUDSON, S.M., & WARD, T. (2000). RELAPSE PREVENTION: ASSESSMENT AND TREATMENT IMPLICATIONS. IN D. R. LAWS (EDS), *REMAKING RELAPSE PREVENTION WITH SEX OFFENDERS* (PP. 102-121). CALIFORNIA: SAGE PUBLICATIONS.

The authors discussed the problems of the Relapse Prevention model as it pertains to treatment and maintenance. They presented a brief summary of the model and examine what the assessment and treatment agenda might look like for each of the pathways of offending patterns associated with the major goals (avoidance vs. approach) and predominant strategy (passive vs. active). They make the point that unless we understand the processes involved for an individual offender, how can we credibly identify areas for clinical intervention? The article proposed having assessment and intervention strategies that reflect the heterogeneity present in the offending process. Further, the authors suggested that we need to gain greater clarity concerning the type of offense process exhibited by various offenders (i.e., an adequate taxonomy) in order to differentially evaluate intervention outcomes. The authors asserted that the global strategy of whether treatment works is inadequate because we predict that some types of the offending process are likely to be more difficult to change and maintain.

LAUNAY, G. (2001). RELAPSE PREVENTION WITH SEX OFFENDERS: PRACTICE, THEORY AND RESEARCH. *CRIMINAL BEHAVIOR AND MENTAL HEALTH*, 11, 38-54.

The aim of this article was to evaluate the Relapse Prevention (RP) technique by looking at evidence presented by the Rochester Relapse Prevention program as well as reviewing the theoretical and research basis for the program. Relapse Prevention is used to help offenders understand the interaction of the behavioral, affective and cognitive factors as well as the steps involved that lead to the offending behavior. The program enabled them to generate and practice alternative strategies in order to halt this cycle. The theory on which relapse prevention for sex offenders is based is sound in essence, but the Relapse model suffers from an overlay of cumbersome vocabulary and from the recent addition of some complex constructs that are not clinically useful. Second, there is some reliable research to support the practice of RP even though the crucial findings that would inform its development are still missing. Launay concluded that the original model provides sound principles for therapy to which the modern revisions add little.

LAWS, D.R., HUDSON, S.M., & WARD, T. (2000). THE ORIGINAL MODEL OF RELAPSE PREVENTION WITH SEX OFFENDERS: PROMISES UNFULFILLED. IN D.R. LAWS (ED.). *REMAKING RELAPSE PREVENTION WITH SEX OFFENDERS* (PP. 3-24). CALIFORNIA: SAGE PUBLICATIONS.

This chapter provided an historical background of the Relapse model and critiqued the original model. The authors questioned whether the Relapse model, as was intended, provides us with insight into offending behavior as well as its efficacy in reducing recidivism. They concluded that the issue of scope, or the lack thereof, is a fundamental criticism of the model. Furthermore, it is reported that the model is contradictory with respect to the mechanisms proposed. For example, sometimes phenomena are simply being described while at other times, incompatible mechanisms are proposed in addition to mechanisms that are more complex than required.

LAWS, D.R. (1999). RELAPSE PREVENTION: THE STATE OF THE ART. *JOURNAL OF INTERPERSONAL VIOLENCE*, 14 (3), 285-302.

This article summarized the development of the Relapse Prevention treatment model through the past 20 years. The author described the original model applied to addictive behavior as conceived by Marlatt and his associates. It proved necessary to make alterations to the classical model in order to make it applicable to sexual offenders. The author postulated that the use of the RP model should be confined to disorders of impulse control. Present and future developments in RP include recognition of the concept of harm reduction, use of stepped care, emphasis on motivational interviewing, the revised cognitive-behavior chain, and recognition of cognitive deconstructionism. The greatest weakness of the RP model is that it has escaped empirical evaluation. Future prospects for the model are discussed, and it is recommended that a revised RP be the model for sexual offender treatment for the foreseeable future.

MCGRATH, R.J., HOKE, S.E., & VOJTISEK, J.E. (1998). COGNITIVE-BEHAVIORAL TREATMENT OF SEX OFFENDERS: A TREATMENT COMPARISON AND LONG-TERM FOLLOW-UP STUDY. *CRIMINAL JUSTICE AND BEHAVIOR*, 25 (2), 203-225.

Recidivism rates were examined for 122 sex offenders from a rural Vermont county who were under correctional supervision from 1984 through 1995. Seventy-one non-randomized participants were enrolled in a comprehensive outpatient cognitive-behavioral and relapse-prevention based treatment program, 32 participants received less specialized mental health treatment, and the remaining 19 participants received no treatment. At follow-up, the cognitive-behavioral treatment group demonstrated a statistically significant treatment benefit. This finding is consistent with previous research findings.

MARSHALL, W.L., ANDERSON D., & FERNANDEZ, Y. (1999). *THE DEVELOPMENT OF COGNITIVE BEHAVIORAL TREATMENT OF SEX OFFENDERS* (PP. 9-31). ENGLAND: JOHN WILEY & SONS, LTD.

This chapter provided an historical overview of sex offender treatment up to the development of cognitive behavioral approaches. Cognitive issues were directly brought into mainstream behavior therapy in the mid-1970s. The authors discussed the use of attachment theory and its relevance to sex offender treatment.

PITHERS, W.D. (1990). RELAPSE PREVENTION WITH SEXUAL AGGRESSORS: A METHOD FOR MAINTAINING THERAPEUTIC GAIN AND ENHANCING EXTERNAL SUPERVISION. IN W.L. MARSHALL (ED.). *HANDBOOK OF SEXUAL ASSAULT: ISSUES, THEORIES, AND TREATMENT OF THE OFFENDER* (PP. 343-361). NEW YORK: PLENUM PRESS.

This chapter described the premise behind Relapse Prevention (RP) and treatment procedures. Pithers stressed that since RP is a highly individualized approach to therapy, thorough assessment is necessary in order to determine the issues to focus upon in treatment. The assessment of high-risk situations is outlined and an External Supervisory Dimension of the RP model is discussed. In conclusion, the author reported data from a five-year follow-up study of 167 offenders (20 rapists, 147 pedophiles) who were treated under the RP model. The data revealed a 4% relapse rate. The author claimed that this initial data suggests that relapse prevention represents an effective means of enhancing maintenance of change in sexual aggressors.

PITHERS, W.D., KASHIMA, K.M., CUMMING, G.F., BEAL, L.S., & BUELL, M.M. (1988). RELAPSE PREVENTION OF SEXUAL AGGRESSION. *ANNALS OF THE NEW YORK ACADEMY OF SCIENCES*, 528, 244-260.

The authors reported that an early meta-analysis of relapse data revealed that nearly 66% of all relapses occurred within the first 90 days after the end of treatment. The probability of relapse decreased markedly after that period. However, when it comes to sex offenders, the first nine months after discharge is the time period marked by the highest recidivism rate. The authors attributed the longer period prior to relapse for sex offenders to the more severe violations of social norms inherent in their acts and the greater penalties imposed for their behavior than for the relapse of a substance abuser. The authors outlined a study that they had conducted that analyzed precursors to offenses of 136 pedophiles and 64 rapists. They looked at multiple determinants of sexual aggression in an effort to identify a relapse process occurring over a longer time. They found that 89% of the subjects reported experiencing strong emotional states prior to relapse; 46% of pedophiles more frequently recalled having felt anxious or depressed (38%), generally as a consequence, or cause, of prolonged social disaffiliation. In analyzing precursors, a common sequence of changes that ultimately led to a sexual offense was often found. The first change in the relapse process from the client's typical function was a change in affect. They referred to themselves as "feeling moody," or "brooding." The second alteration involved fantasies of performing the aberrant sexual act. These fantasies were converted into thoughts, often cognitive distortions, in the third step of the relapse process. As fantasies and thoughts continued, the clients engaged in a process of passive planning, cognitively refining the circumstances that would permit commission of a sexual offense. In the final step of the relapse process, the plan was manifested behaviorally. The article went on to outline Relapse Prevention (RP) assessment and treatment procedures. The authors concluded that RP serves as a comprehensive training program designed to help sex offender avoid reoffenses. It is stressed that RP is not an activity that a sex offender completes and the crucial lesson is that maintenance is forever.

PITHERS, W.D., MARQUES, J.K., GIBAT, C.C., & MARLATT, G.A. (1983). RELAPSE PREVENTION WITH SEXUAL AGGRESSIVES: A SELF-CONTROL MODEL OF TREATMENT AND MAINTENANCE CHANGE. IN J.G. GREER (ED.). *THE SEXUAL AGGRESSOR: CURRENT PERSPECTIVES ON TREATMENT* (PP. 214-239). NEW YORK: VAN NOSTRAND REINHOLD.

This chapter described Relapse Prevention (RP) as a systematic assessment and treatment program designed to provide sexually aggressive individuals with cognitive and behavioral skills that will reduce the probability of another offense. The model enhances maintenance of changes that have been induced by other treatments (e.g. presents a description of the sequence of behavioral changes that ultimately culminates in relapse). The authors outlined the basic concepts and terms of relapse prevention and provided a thorough description of the behavioral assessment and treatment components of the relapse prevention treatment model for sexual aggressors.

STONER, S.A., & GEORGE, W.H. (2000). RELAPSE PREVENTION WITH HARM REDUCTION: AREAS OF OVERLAP. IN D.R. LAWS (ED.). *REMAKING RELAPSE PREVENTION WITH SEX OFFENDERS* (PP. 56-75). CALIFORNIA: SAGE PUBLICATIONS.

The authors considered the merits of applying harm reduction to sex offender treatment paradigms. They described harm reduction and reviewed and updated key Relapse Prevention constructs in order to foster better reconciling with harm reduction. The authors also addressed several of the challenges involved with translating harm reduction to sex offender work. The issues of lapse and relapse, the cognitive-behavioral offense chain, and the abstinence violation effect, concepts that are central to RP, are also central to an understanding of how a harm reduction philosophy might be beneficial. In conclusion, the authors were optimistic that harm reduction may be profitably applied to sex offender treatment protocols; however, they acknowledge that this concept is still relatively new and requires further investigation.

WARD, T., & HUDSON, S.M. (2000). A SELF-REGULATION MODEL OF RELAPSE PREVENTION. IN D.R. LAWS (ED.). *REMAKING RELAPSE PREVENTION WITH SEX OFFENDERS* (PP. 79-101). CALIFORNIA: SAGE PUBLICATIONS.

to deviant sexual cravings, as when rape is committed opportunistically or in response to anger and hostility. Stereotactic psychosurgery is still a somewhat controversial procedure that is not yet widely available to be considered a practical treatment option for sexual deviation syndromes at this time. However, behavioral therapy may help some offenders learn how to better resist their urges.

BRADFORD, J.M. (1990). THE ANTIANDROGEN AND HORMONAL TREATMENT OF SEX OFFENDERS. IN W.L. MARSHALL (ED.). *HANDBOOK OF SEXUAL ASSAULT: ISSUES, THEORIES, AND TREATMENT OF THE OFFENDER* (PP. 297-310). NEW YORK: PLENUM PRESS.

This article outlined the use of hormones and other agents in the treatment of sexually deviant behavior. It discussed hormonal controls over sexual behavior, MPA and CPA, and included a review of clinical studies in order to explain both treatment methods. In conclusion, the author provided evidence that the treatment of sex offenders with antiandrogens is clearly successful in reducing recidivism rates. However, he implied that CPA should have limited use in a correctional facility owing to the uncertainty that informed consent may not be gotten freely. There is the danger that CPA is too likely to become part of a subtle coercion process involving the offer of parole contingent on accepting treatment, without a truly independent psychiatric consultation prior to its use. Further, the author indicated that after a treatment period of 6 to 12 months, CPA can be gradually tapered off in a significant number of individuals, without causing relapses, which does not seem to be true for MPA.

GRUBIN, D. (2000). COMPLEMENTING RELAPSE PREVENTION WITH MEDICAL INTERVENTION. IN D.R. LAWS (ED.). *REMAKING RELAPSE PREVENTION WITH SEX OFFENDERS* (PP. 201-212). CALIFORNIA: SAGE PUBLICATIONS.

Grubin discussed the use of medications such as CPA, Depo-Provera and Selective Serotonin Reuptake Inhibitors (SSRI's) in conjunction with cognitive-behavioral treatment. While acknowledging the message that the use of medication sends to the offender (i.e., that his drives are not wholly under his power, and that he has only a limited ability to control his offending behavior), the author supported

the notion that medication can assist in identifying thoughts and emotions that can disrupt self-regulation, as well as providing a means to facilitate it.

HUCKER, S.J., & BAIN, J. (1990). ANDROGENIC HORMONES AND SEXUAL ASSAULT. IN W.L. MARSHALL (ED.). *HANDBOOK OF SEXUAL ASSAULT: ISSUES, THEORIES, AND TREATMENT OF THE OFFENDER* (PP. 93-102). NEW YORK: PLENUM PRESS.

The authors reviewed studies that have evaluated interactions among hormones, sex, and aggression. It discussed the basic physiology of sex hormones in the human male, hormones and sex drive, testosterone-level responses to erotic stimulation, treatment of hypogonadal men with testosterone, the behavioral effects of castration, testosterone and aggression in normal males, testosterone and aggression in male offenders, and hormones and sexual aggression. The authors concluded that the studies reviewed in this article are characterized by small groups of subjects and that results are conflicting. Further evidence suggests that there may be an abnormality of androgen metabolism in individuals who display aberrant sexual behavior, though this is not well supported by empirical evidence.

RÖSLER, A., & WITZTUM, E. (2000). PHARMACOTHERAPY OF PARAPHILIAS IN THE NEXT MILLENNIUM. *BEHAVIORAL SCIENCES AND THE LAW*, 18, 43-56.

This article discussed how CPA, MPA, GnRH and psychotropic drugs work to decrease sex offending behavior. It stated that psychotropic drugs are highly controversial because of the erratic results and lack of permanent eradication of paraphilic manifestations. Long-acting gonadotropin-releasing hormone (GnRH) agonist analogues are the most potent antiandrogens that selectively abolish testosterone secretion in a totally reversible fashion. The article indicated that GnRH analogues, together with psychotherapy, are highly effective in controlling selected paraphilias (pedophilia, exhibitionism, and voyeurism), and these are the most promising mode of therapy in the next millennium. Further, the authors reported that there is an urgent need for strong methodological research. These would consist of carefully designed double-blind controlled studies with a large number of subjects in order to validate or not the use of the various pharmacological therapies.

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CLERIC SEX OFFENDERS AND TREATMENT

BRYANT, C. (1999). PSYCHOLOGICAL TREATMENT OF PRIEST SEX OFFENDERS. IN T.G. PLANTE (ED). *BLESS ME FATHER FOR I HAVE SINNED: PERSPECTIVES ON SEXUAL ABUSE COMMITTED BY ROMAN CATHOLIC PRIESTS* (PP. 87-110). WESTPORT, CT: PRAEGER PUBLISHERS.

This chapter provided an overview of theories concerning offending and treatment. The literature is reviewed in order to provide the reader with different possibilities as to why an individual molests a child. A brief discussion of assessment is included and the author made a distinction between assessment and treatment. Several goals of inpatient treatment are outlined. The priest must acknowledge that he has a sexual problem and that something must be done. This first step facilitates the acceptance of responsibility. It is important that the offender understands what initiates his offending and that he has a firm grasp of the tools used to manage his behavior. The offender must also appreciate the inappropriateness of his behavior and recognize the fact that he can be treated, but never cured. A brief overview of cognitive-behavioral treatment and relapse prevention is included.

HAYWOOD, T.W. & GREEN, J. (2000). CLERIC SERIAL OFFENDERS: CLINICAL CHARACTERISTICS AND TREATMENT APPROACHES. IN LOUIS B. SCHLESINGER (ED.). *SERIAL OFFENDERS: CURRENT THOUGHTS, RECENT FINDINGS* (PP. 247-262). BOCA RATON, FL: CRC PRESS.

Haywood and Green provided an overview of the literature pertaining to prevalence, offense/victim characteristics, and evaluation of cleric serial offenders. Depending upon the study, prevalence rates ranged from 2% to 6% (pedophilic and ephebophilic clerics), 20% to 40% (sexual misconduct with adults), 8.4% (in a sample of 1322), and 5.8% to 24% (boundary violations with adults) (Sipes, 1990; Loftus & Camargo, 1993; Friel & Friel, 1988; Goetz, 1992; Seat et al., 1993). In examining offense/victim characteristics, the authors concluded that clerics are more likely to engage in sexual misconduct with adults than minors. Of those who offend against children they

are more likely to favor adolescent males and they are less likely than non-clerics to be serial offenders or have multiple paraphilias. In examining the literature concerning characteristics of the offender, it is illustrated that in regards to cognitive distortions cleric offenders displayed extreme minimization of personal problems and were less likely to rationalize and justify child molestation. The chapter also provided two case studies, which illustrated offending behavior, evaluation and outcome. In evaluating sex offenders, it is recommended that clinical and actuarial methods be utilized. It is also important to assess sexual preference and the extent of cognitive distortions. The "being a person" (BAP) treatment paradigm is discussed, which includes 100 items that help mold the course of therapy. In discussing relapse prevention the red light/green light metaphor is used to help teach offenders how to manage their behavior.

HUDSON, P.E. (1997). SPIRITUALITY AS A COMPONENT IN A TREATMENT PROGRAM FOR SEXUALLY ADDICTED ROMAN CATHOLIC CLERGY. *COUNSELING & VALUES*, 41 (2), 174-183.

This article described a European program for cleric sex offenders that is based on spirituality. The article also featured an interview with the head of the treatment program, David Fitzgerald. The program includes only Roman Catholic priests and brothers from Africa and Europe who are typically fixated/regressed pedophiles and ephebophiles. The philosophy of this 12-step program is that addiction results from a spiritual void that is combated through prayer, meditation, and scripture reading. Success is measured through identification of high-risk situations and mastery of the tools presented in the program for managing offending behavior. It is required that the men participate in two years of aftercare. Fitzgerald asserted that those individuals for whom treatment had proved unsuccessful will be reported to civil authorities if there is an indication that the Diocese or community would fail to report that person.

KELLY, A.F. (1998). CLERGY OFFENDERS. IN W.L. MARSHALL ET AL. (EDS.). *SOURCEBOOK OF TREATMENT PROGRAMS FOR SEXUAL OFFENDERS* (PP. 303-318). NEW YORK, NY: PLENUM PRESS.

This chapter provided an overview of the problems associated with managing cleric offenders. The author cited the reforms made by the Chicago Archdiocese in 1992, which instituted a policy of removal for any priests who had been accused of abuse. The Archdiocese also established a review board comprised of lay persons not associated with the Church, as well as psychologists, psychiatrists, and lawyers. This revision is concurrent with the suggestions made by the Canadian bishops Ad Hoc Committee on Child Sexual Abuse in 1992. In 1993, various experts in the field of child sexual abuse met with the National Conference of Catholic Bishops in order to evaluate the problems in the Church. Among the suggestions included improving the care allotted to victims, improving education and the screening of candidates for the seminary, and creating guidelines for relapse prevention and reassignment. The author posited that the abuse is made possible by the cleric's position of power and that the problem extends beyond the individual. Among the problems involved in establishing treatment facilities include the societal stigma associated with cleric offenders. Since child sexual abuse by members of the clergy has become a public issue, some hospitals may not want to institute a program for fear of having to deal with the swarms of media. Thus, this hinders the treatment program, which may be forced to act in secrecy. The surrounding community will also pose a challenge to establishing a program as the offender may resist treatment for fear of being ostracized by fellow priests. In combating these issues, confidentiality must be handled with care. The therapeutic alliance may be hindered when the treatment referral is mandatory and the cleric may feel that there is a political motive behind the referral. These ulterior motives foster a sense of resistance to cooperation and the offender becomes defensive in talking about himself. Cleric offenders differ from the general population in the fact that they have a built in alliance and sense of caring and community as a result of their work. This may assist in creating a helpful, productive relationship. In assessing the cleric, Kelly asserted that the assessment at the very least should consist of a series of clinical interviews, a complete sexual history, personality testing, cognitive and neuropsychological testing, and a physical examination. The treatment center must be viewed as a neutral party and may accomplish this by

having a Church representative clearly spell out the allegations in front of the cleric and evaluator. According to Kelly, this creates an air of openness and implies that "yes, we know all of this, and we still care about you and want to help you." During the course of the evaluation, a spiritual assessment should be conducted because clerics often profess that at the time of the offense their prayer life was seriously hindered. The Church is expected to refer all alleged offenders for an evaluation in order to defend against an allegation. Another issue, which must be addressed in evaluations, is the vague criteria for what constitutes an effective cleric. Kelly asserted that psychosis, antisocial characteristic traits and paraphillias are definite rule outs, but the positive behaviors are more vague and possibly immeasurable. There has also been resistance directed towards the use of the penile plethysmograph (PPG) to evaluate sexual deviancy due to its intrusive nature and stimulus material. Thus, this assessment technique is not used often with the cleric. The true prevalence of cleric abuse is unknown but it has been estimated that 2% to 3% may have acted out sexually with a child. There is also the myth that these offenders are true pedophiles who engage in predatory acts, but Kelly contends that this is false. In citing the work of Father Canice Connors, former director of St. Luke's Institute, 44 priests were diagnosed as pedophiles, 185 were ephebophiles, 142 were compulsives, and 165 were diagnosed with unintegrated sexuality. The treatment center must also be prepared to respond to the needs of the parish. This can be achieved through organizing educational programs and providing counseling to those members of the laity who are likely to feel hurt and betrayed. In communicating with the Church regarding the progress of the cleric, it is recommended that the cleric review every written communication and sign it before it is shared. While the treatment center should not be biased in any manner, being biased in favor of the cleric can enable treatment progress since they usually display a trust of self and others. Characteristics of cleric offenders are discussed and the subjugation of self makes treatment very difficult in the beginning. They have limited awareness of their emotional life, poor use of leisure time, poor physical health, and underdeveloped relations and may also profess that their role is to be concerned with the well being of others

and not themselves. This idea must be challenged in treatment and it must be explained that if they can not help themselves then they will be ineffective in helping others. Intimacy must be addressed during treatment in order to develop a sense of interpersonal security. Intimacy building also allows the treatment provider to teach the cleric healthy strategies to deal with emotions. Shame and guilt must also be addressed during the treatment progress since shame reinforces denial, which is an unfavorable evaluation of the self. Shame may also serve to annihilate the self for those clerics who have not developed a sense of self, which is separate from their vocation. Clerics are placed upon a moral pedestal by the parish and a lapse in moral behavior is devastating because of these high standards. Guilt may be used in a healthy manner since it is an unfavorable view of behavior, not the self, and may be used to prevent future behavior whereas shame may perpetuate it. The presence of grandiosity in the cleric results in a minimization of abuse and blame being directed towards the victim. This is evident in those clerics who have an insecure sense of self and display a need to rely on the parishioners who idolize him. This idolatry and lack of intimacy play a role in facilitating boundary violations. Once the initial denial stage has been combated, clerics are likely to regret their actions and vow never to do it again. Due to their intelligence and alienation from emotions, these vows are hollow because while they may have made up their minds, they have not yet found a way to control their emotions. Empathy deficits may be present in those clerics who have lost touch with the needs of others and only seek to fulfill their selfish wishes and issues with authority may be played out in the boundary violation. Treatment aftercare is discussed and it is emphasized that psychotherapy should be continued for a minimum of 6 months to a year. A support team should also be established with at least one member of the Church hierarchy on the committee. This team would enable the cleric to communicate his feelings with someone whom he knows will be there to care for him whenever he needs it. The cleric should also be required to attend a 12-Step meeting and discuss it with his therapist in order to ensure that the program is meeting his needs. The issue of reassignment and the legal implications associated with child abuse are briefly discussed.

LOFTUS, J.A. & CAMARGO, R.J. (1993). TREATING THE CLERGY. *ANNALS OF SEX RESEARCH*, 6, 287-303.

This article described a study conducted over a two-year period at the Southdown Treatment Center for cleric offenders. WAIS and MMPI scores from the past 25 years were compared for the sample that was comprised of clerics described as age inappropriate offenders, homosexual, heterosexual, and bisexual. These scores were then compared to those of a control group comprised of clerics in order to establish a baseline. The authors found evidence that 2.7% of the clerics in the age inappropriate group had contact with children under age of 13. The following characteristics emerged in analyzing the data concerning the age inappropriate group: most were priests from Dioceses, they were between the ages of 49 and 60 when they were first referred for treatment, they ministered in parishes and educational settings, there was no criminal or psychiatric history for the individual clerics or their families, and they had no history of substance abuse. The offense data illustrated that the abuse occurred frequently (four or more times) and the ages of the victims varied. The MMPI data suggested that the personality profile for the clerics was comprised of shy, passive, and lonely characteristics. In evaluating their treatment, the authors urged that clerics should be treated no differently from other sex offenders. They have had some evidence that non-verbal psychotherapies have been helpful because the patients show signs of being alienated from their body before entering treatment. Recidivism is discussed with caution because out of the 111 men in the sample, the treatment providers know the status of only 40 individuals. Based upon these figures, there appeared to be a recidivism rate of 10%.

MANUEL, G. (1999). BEGINNING AN INTERVENTION IN CLERGY SEXUAL ABUSE. IN T.G. PLANTE (ED). *BLESS ME FATHER FOR I HAVE SINNED: PERSPECTIVES ON SEXUAL ABUSE COMMITTED BY ROMAN CATHOLIC PRIESTS* (PP. 22-26). WESTPORT, CT: PRAEGER PUBLISHERS.

This chapter is based upon the author's own experience as a clinician and provided a brief overview of the various considerations that must be taken into account when staging an intervention. The mental health professional must be aware of the mandatory reporting laws for child sexual abuse as

well as the sexual misconduct policies and procedures the institution. It is important that the mental health professional alert Church authorities that they must pay serious attention to their reactions and they must be made aware of the issue of denial. Withdrawing from the intervention is appropriate if the religious superior will not allow for a fair intervention. The issues of shame and guilt must be addressed in order to make religious superiors aware of the need for neutrality. The mental health professional is also responsible for educating the religious superiors as to how they should address the victim and the perpetrator in a manner that is clear and effective.

VALCOUR, F. (1990). THE TREATMENT OF CHILD SEXUAL ABUSERS IN THE CHURCH. IN S.J. ROSSETTI (ED.). *SLAYER OF THE SOUL: CHILD SEXUAL ABUSE AND THE CATHOLIC CHURCH* (PP. 45-66). MYSTIC, CT: TWENTY-THIRD PUBLICATIONS.

Valcour described different forms of treatment and risk factors associated with sexual offending. The author asserts that while sexual deviancy is not curable, it can be treated and cites the success of the Saint Luke Institute (of the 55 child molesting priests none are known to have relapsed). Certain risk factors such as chromosomal abnormalities are unalterable and the evaluator must pay attention to the perpetrators own childhood trauma because the offending may be a form of acting out. These traumas also stunt the psychological development of these individuals. Valcour asserts that in conjunction with the previously mentioned risk factors, early experiences, hormonal problems, neuropsychological deficits, denial, and countertransference also play a role in the offending behavior and treatment survival. The problems involved in psychotherapeutic interventions include idealization, authority conflict, control issues, self-loathing, and a need for forgiveness. While these are fairly common, the individual may be hindered by other problems such as paraphilias, eating disorders, and depression. An alternative form of treatment involves the hormone Depo-Provera, which stifles sexual arousal but has numerous side effects. Valcour contends that before reassignment can be considered for the priests, a formal appraisal of the individual's risk of reoffending must be obtained from the treatment center. It is considered encouraging if the priest has

displayed insight into his disorder and is committed to preventing the recurrence of the behavior. Insight into one's own risk factors, a willingness to disclose problems, and participation in an aftercare program are also encouraging. In order for aftercare to be successful the diocese needs to create and enforce certain guidelines that spell out the conditions for reassignment.

WARBERG, B.W., ABEL, G.G., & OSBORN, C. (1996). COGNITIVE-BEHAVIORAL TREATMENT FOR PROFESSIONAL SEXUAL MISCONDUCT AMONG THE CLERGY. *PASTORAL PSYCHOLOGY*, 45 (1), 49-63.

This article explained cognitive-behavioral therapy with clerics through discussion of case studies. The authors asserted that clergy offenders describe their misconduct as being sudden, impulsive, and unplanned. Through various methods, therapists are able to teach clerics that the behavior is anything but impulsive and can be interrupted early in the process. The authors also discussed the role of cognitive distortions and their impact on treatment outcome. Professional sexual misconduct treatment failures are more prone to have sustained rationalizations and justifications. Victim empathy in clerics is examined and certain factors prevent the minister from understanding the harm he has inflicted. Failure to appreciate the power differentiation between minister and parishioner, naivety about sexual issues/minimal training in transference/countertransference, and desensitization of the intimacy of the minister/laity relationship all combine to affect victim empathy. The presence of paraphilias must also be evaluated when assessing treatment needs. The authors asserted that 20% of professional sexual misconduct cases were found to have a history of prior paraphilias. It is stressed that interpersonal and emotional factors (anxiety, stress, depression, deficits in social/assertive skills, alcohol/drug abuse, personality disorders/intrapsychic conflicts) play a role in the development of professional sexual misconduct. In order to ensure the safety of the minister and congregation, those who have engaged in sexual misconduct must be thoroughly evaluated and placed under constant surveillance by staff. These individuals must be trained in recognizing the ministers offending behavior. The congregation can also serve as a source for evaluating the minister's behavior through the administration of a "bill of rights", which outlines

appropriate minister/Church member behavior. When the sexual misconduct is rampant, steps must be taken in order to manage the clerics. Prohibitions may be implemented that prevent the minister from working with parishioners. In order

to protect the congregation, the authors recommend that close monitoring be implemented. Thus far, group therapy sessions that include various professional who have been involved in sexual misconduct have shown promise.